Exhibit 13

AMERICAN NATIONAL

Application for Life Insurance

Issued by American National Insurance Company
One Moody Plaza, Galveston, TX 77550-7947

45937e11

1. PRIMARY PROPOSED INSURED

a. Last name: Sherlock | First name: Caroline | M.I.: C. | b. Birthplace: City: Augusta | State: GA | Country: USA

c. Date of birth: Month/Day/Year: PII | d. Age last birthday: 36 | e. Height: 5'4" | f. Weight: 157 | g. Social Security/Tax ID number: PII -3002

h. Gender ☐ Male ☒ Female | i. Marital status: ☒ Married ☐ Separated ☐ Single ☐ Widowed ☐ Divorced

j. Have you ever used tobacco or nicotine in any form? ☐ Yes ☒ No
(Tobacco or nicotine includes cigarettes, cigars, pipes, chewing tobacco, nicotine patches or other products containing nicotine. If "Yes," when was tobacco or nicotine last used?) Month/Year:

k. Residence address: Number/Street: 61 Murphy St | City: North Augusta | State: S.C. | ZIP: 29860

l. Years at this residence: life | m. Personal telephone: PII | n. Annual Income: $ 60,000 | Net worth: $ 450,000

o. Type of business: Carpet & Vinyl | Employer name: Self-employed | p. Business telephone: (803) 439-8843

q. Occupation/Job title: Salesman | Job duties *(Be specific.)*: Salesman/manager | r. Date of employment: Month/Year

s. Business address: Number/Street: 61 Murphy St. | City: North Augusta | State: S.C. | ZIP: 29860

t. U.S. Citizen: ☒ Yes ☐ No If No, type of Visa: | Expiration Date:

2. ADDITIONAL PROPOSED INSURED

a. Last name | First name | M.I. | b. Birthplace: City | State | Country

c. Date of birth: Month/Day/Year | d. Age last birthday | e. Height | f. Weight | g. Social Security/Tax ID number

h. Gender ☐ Male ☐ Female | i. Marital status: ☐ Married ☐ Separated ☐ Single ☐ Widowed ☐ Divorced

j. Have you ever used tobacco or nicotine in any form? ☐ Yes ☐ No
(Tobacco or nicotine includes cigarettes, cigars, pipes, chewing tobacco, nicotine patches or other products containing nicotine. If "Yes," when was tobacco or nicotine last used?) Month/Year:

k. Residence address: Number/Street | City | State | ZIP

l. Years at this residence | m. Personal telephone | n. Annual Income: $ | Net worth: $

o. Type of business | Employer name | p. Business telephone | q. Relationship to primary proposed insured

r. Occupation/Job title | Job duties *(Be specific.)* | s. Date of employment: Month/Year

t. Business address: Number/Street | City | State | ZIP

u. U.S. Citizen: ☐ Yes ☐ No If No, type of Visa | Expiration Date

3. OWNER (IF OTHER THAN PRIMARY PROPOSED INSURED)

a. Last name | First name | M.I. | b. Relationship to primary proposed insured

c. Gender ☐ Male ☐ Female | d. Date of birth: Month/Day/Year | e. Age last birthday | f. Social Security/Tax ID number | g. If Trust, date created

h. Mailing address: Number/Street | City | State | ZIP

i. Contingent owner *(If any)*: Last name | First name | M.I. | j. Relationship to primary proposed insured

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4. SECONDARY OR ALTERNATE ADDRESSEE (Optional Secondary Addressee for notification of past due premiums)

Name | _____ Address: Number/Street | _____

City | _____ State | _____ ZIP | _____

5. CHILDREN PROPOSED FOR INSURANCE (COMPLETE FOR CHILDREN TERM RIDER)

Last name	First name	M.I.	Relationship to primary proposed Insured	Date of Birth: Mo./Day/Yr.	Age	Ht./Wt.	Gender: M/F	Soc. Sec./Tax ID#

a. Has the name of any child age 18 or younger been omitted? ☐ Yes *(Explain.)* | _____ ☐ No

b. Is any child NOT living at the same address as the proposed Insured? ☐ Yes *(Explain.)* | _____ ☐ No

6. BENEFICIARY FOR PRIMARY PROPOSED INSURED (Unless specified, all beneficiaries in the same class share equally.)

Primary: Last name	First name	M.I.	Relationship to primary proposed Insured	Date of Birth: Mo./Day/Yr.	Gender: M/F	Soc. Sec./Tax ID#	Date of trust: Mo./Day/Yr.	% payable
Shenlock	Pete	J	Husband	PII-58		PII 0106		100%

Contingent: Last name	First name	M.I.	Relationship to primary proposed Insured	Date of Birth: Mo./Day/Yr.	Gender	Soc. Sec./Tax ID#	Date of trust: Mo./Day/Yr.	% payable

Special beneficiary settlement options: ☐ Yes ☒ No *(If "Yes," complete and submit the state appropriate form for Additional Beneficiary Page.)*

7. BENEFICIARY FOR ADDITIONAL PROPOSED INSURED (Unless specified, all beneficiaries in the same class share equally.)

Primary: Last name	First name	M.I.	Relationship to additional proposed Insured	Date of Birth: Mo./Day/Yr.	Gender: M/F	Soc. Sec./Tax ID#	Date of trust: Mo./Day/Yr.	% payable

Special beneficiary settlement options: ☐ Yes ☐ No *(If "Yes," complete and submit the state appropriate form for Additional Beneficiary Page.)*

8. PRODUCT INFORMATION

a. Plan of insurance (Specify number of years if Term) ANICO Signature Term 30yr

b. Amount of Insurance 250,000

c. Premium amount $ 42.77 Mode: ☐ Annual ☐ Semiannual ☐ Quarterly ☒ Monthly ☐ Single premium

d. If all proposed insured(s) are acceptable risks on a nonrated basis, but the premium quoted will not purchase the face amount requested:
☐ Do NOT change premium. Change face amount. ☐ Do NOT change face amount. Change premium.

Was automatic premium loan elected? ☐ Yes ☐ No *(In Rhode Island, automatic premium loan is required, unless otherwise elected.)*

If Participating Whole Life

e. Dividend option: ☐ Cash ☐ Premium reduction ☐ Paid-up additions ☐ Accumulate at Interest

If Universal Life *(including Indexed Universal Life and Variable Universal Life)*

f. Death benefits options (Elect one - If no option is selected, Option "A" will be issued) ☐ Option A ☐ Option B ☐ Option C

If Indexed Universal Life

g. Initial Allocation of Net Premiums (Allocation must be designated in percentages and must total 100%)
_____% Fixed Interest Crediting Option _____% Indexed Interest Crediting Option

If Variable Universal Life

h. Guaranteed Coverage Period: *(Elect one.)* ☐ 10-year ☐ 25-year ☐ Other _____

Amount paid with application: $ _____ *(Check must be payable to American National Insurance Company.)*

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9. RIDERS/BENEFITS *(Complete insurability application, if necessary.)*

a. Optional benefits/riders:

- ☐ Premium waiver
- ☐ Waiver of stipulated premium $ _____
- ☐ Accidental death $ _____
- ☐ Children term $ _____
- ☐ Spouse term $ _____
- ☐ Guaranteed increase option $ _____
- ☐ Additional insurance option $ _____
- ☐ Return of Premium Rider
- ☐ Paid Up Additions Rider _____ Premium for PUA $ _____
- ☐ Premium payor *(Complete insurability application.)*
- ☐ Coverage continuation rider
- ☐ Other insured rider *(designate beneficiary below)*
- ☐ Level term $ _____

☐ Other: Type of Rider | Name of Insured | Amount of Insurance $

Beneficiary for Other Insured Rider Coverage *(Unless specified, all beneficiaries in the same class share equally.)*

Primary: Last name	First name	M.I.	Relationship to other insured rider	Date of Birth: Mo./Day/Yr.	Gender: M/F	Soc. Sec./Tax ID#	Date of trust: Mo./Day/Yr.	% payable

Special beneficiary settlement options: ☐ Yes ☒ No *(If "Yes," complete and submit the state appropriate form for Additional Beneficiary Page.)*

10. INSURANCE AND REPLACEMENTS

a. Do you have existing life insurance or annuity coverage? ☐ Yes ☒ No If yes, provide details below.

b. Will the insurance applied for replace or use cash values of any existing life insurance or annuity issued by any company? ☐ Yes ☒ No
If "yes", indicate which one. **Agent must provide and complete the appropriate replacement form.**

c. Total Insurance/Annuities in force on Proposed Insured(s): If none in force indicate "NONE".

Full Name of Company	Policy No.	Issue Date	Insured's Name	Plan	Amount	See "10b"

☐ Accidental Death $ _____ Company _____

11. PRIMARY PROPOSED INSURED FAMILY HISTORY - COMPLETE IF AMOUNT OF INSURANCE IS $100,000 OR GREATER

Parents:	Is parent living (Y/N)	Age if living	Age at death	Cause of death
Father	Johnny Carroll	63		
Mother	Ann Carroll	63		

Siblings:	Number of living	Number deceased	Age at death	Cause of death
	3			

a. Did (Does) anyone in the immediate family have a history of heart disease or stroke/cerebral vascular accident? ☐ Yes ☒ No
Age at diagnosis | _____

b. Did (Does) anyone in the immediate family have a history of internal cancer or melanoma? ☐ Yes ☒ No
Type | _____ Age at diagnosis | _____

12. ADDITIONAL PROPOSED INSURED FAMILY HISTORY - COMPLETE IF AMOUNT OF INSURANCE IS $100,000 OR GREATER

Parents:	Is parent living (Y/N)	Age if living	Age at death	Cause of death
Father				
Mother				

Siblings:	Number of living	Number deceased	Age at death	Cause of death

a. Did (Does) anyone in the immediate family have a history of heart disease or stroke/cerebral vascular accident? ☐ Yes ☐ No
Age at diagnosis | _____

b. Did (Does) anyone in the immediate family have a history of internal cancer or melanoma? ☐ Yes ☐ No
Type | _____ Age at diagnosis | _____

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13. FAMILY PHYSICIAN, SPECIALIST, OR CLINIC

a. Family physician, specialist or clinic of proposed insured:

Provider name | Date last visited | Reason for visit | HMO patient ID number

Address: Number/Street | City | State | ZIP | Provider telephone number

b. Family physician, specialist or clinic of additional proposed insured:

Provider name | Date last visited | Reason for visit | HMO patient ID number

Address: Number/Street | City | State | ZIP | Provider telephone number

14. MEDICAL HISTORY QUESTIONS—LIFETIME

(For questions "14.a." through "16.c.", underline the reason for any "Yes" answer(s) and give complete details as requested in Section 17.)

a. Is any proposed insured taking any medication(s)? ☐ Yes ☒ No *(If "Yes," list medications and prescribed dosages).*

HAS ANY PROPOSED INSURED EVER BEEN DIAGNOSED, TREATED, TESTED POSITIVE FOR, OR BEEN GIVEN MEDICAL ADVICE BY A MEMBER OF THE MEDICAL PROFESSION FOR A DISEASE OR DISORDER FOR ...

b. a heart attack, heart murmur, chest pains, irregular heartbeat, stroke, high blood pressure, anemia or any disease or abnormality of the heart, blood or blood vessels?

c. cancer, a tumor or abnormal growth of any kind?

d. been told he/she had an Immune Deficiency Disorder, AIDS, AIDS related complex (ARC), or test results indicating exposure to the AIDS virus?

PII

15. MEDICAL HISTORY QUESTIONS— LAST TEN YEARS

HAS ANY PROPOSED INSURED, WITHIN THE LAST TEN YEARS BEEN DIAGNOSED, TREATED, TESTED POSITIVE FOR, OR BEEN GIVEN MEDICAL ADVICE BY A MEMBER OF THE MEDICAL PROFESSION FOR A DISEASE OR DISORDER FOR ...

a. seizure, depression, anxiety, psychiatric treatment or counseling, paralysis, dizziness or any disease or abnormality of the brain or nervous system?

b. asthma, emphysema, chronic bronchitis, sleep apnea, tuberculosis, chronic obstructive pulmonary disease (COPD) or any disease or abnormality of the respiratory system?

c. any disease or abnormality of the stomach, intestines, rectum, pancreas, or liver, including cirrhosis, hepatitis and colitis?

d. any disease or abnormality of the kidneys, urinary bladder, prostate or genital system, including sugar or blood in the urine?

e. diabetes or any disease of the thyroid or other gland?

f. arthritis, lupus, physical deformity, any disease of the bones, muscles or joints, or any disease or abnormality of the eyes, ears or skin?

g. treatment or counseling for use of alcohol or alcoholism?

h. treatment or counseling for drug use or used marijuana, cocaine, heroin, barbiturates, amphetamines, hallucinogenics, narcotics or other habit-forming drugs, other than those prescribed by a physician?

i. Does any proposed insured currently have any medical concerns for which you have not consulted a doctor or had any consultation, testing or investigation recommended by a doctor which has not yet been completed?

j. If any proposed insured(s) is less than one year old, give birth weight: | ___ lb. | ___ oz. Was birth premature?

PII

16. MEDICAL HISTORY QUESTIONS— LAST FIVE YEARS

HAS ANY PROPOSED INSURED, WITHIN THE LAST FIVE YEARS ...

a. consulted or been treated or examined by any physician or practitioner for any cause not previously mentioned in this application?

b. had treadmill EKG or other cardiovascular test, chest X-ray, blood or other laboratory test?

c. had a surgical operation or been under observation or treatment in any hospital or clinic or been advised to have an operation which was not performed

PII

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17. MEDICAL HISTORY EXPLANATIONS

(Give full details below of all "Yes" answers to questions "14.a." through "16.c.")

Question Person | Reason, condition, disease, injury, etc. | Date

% of recovery | Name of attending physician | Attending physician address: Number/Street | City | State

Question Person | Reason, condition, disease, injury, etc. | Date

% of recovery | Name of attending physician | Attending physician address: Number/Street | City | State

Question Person | Reason, condition, disease, injury, etc. | Date

% of recovery | Name of attending physician | Attending physician address: Number/Street | City | State

Question Person | Reason, condition, disease, injury, etc. | Date

% of recovery | Name of attending physician | Attending physician address: Number/Street | City | State

Question Person | Reason, condition, disease, injury, etc. | Date

% of recovery | Name of attending physician | Attending physician address: Number/Street | City | State

18. INSURANCE HISTORY AND NON-MEDICAL HAZARDS

a. Has any proposed insured, in the past five (5) years, applied for life, accident or health insurance or for reinstatement of any such insurance that was declined, postponed, cancelled or withdrawn or modified as to plan, amount or rate? ☐ Yes ☒ No *(If "Yes," give details.)*

b. Has any proposed insured in the last six (6) months, applied for – or is any proposed insured contemplating applying for – other insurance with this, or any other, company? ☐ Yes ☒ No *(If "Yes," state how much and to whom.)*

c. Has any proposed insured, in the past five (5) years, made – or is any proposed insured contemplating making – flights as a pilot, student pilot, crew member, or observer? ☐ Yes ☒ No *(If "Yes," complete and submit the appropriate questionnaire.)*

d. Has any proposed insured, in the past five (5) years, engaged in or does any proposed insured intend to engage in mountain climbing, rock climbing, racing, SCUBA diving, hang-gliding, ballooning or skydiving? ☐ Yes ☒ No *(If "Yes," complete and submit the appropriate questionnaire.)*

e. Has any proposed insured, in the past five (5) years, been convicted of a felony? ☐ Yes ☒ No *(If "Yes," give details including county and state of conviction.)*

f. Is any proposed insured currently on parole or probation? ☐ Yes ☒ No *(If "yes", give details.)*

g. Has any proposed insured in the last two (2) years resided outside of the United States for more than four (4) weeks? ☐ Yes ☒ No

h. Does any proposed insured plan to travel outside of the United States for more than four (4) weeks? ☐ Yes ☒ No
(If "Yes," complete and submit the Foreign Travel Questionnaire.)

Primary Proposed Insured

PII

i. Driver's license number: | _____ State: | S.C 4-19-17

j. Have you had a charge or conviction of DWI/DUI or reckless driving in the last five (5) years? ☐ Yes ☒ No
(If "yes", give details.) |

k. Do you have any other moving violations in the last five (5) years? ☐ Yes ☒ No
(If "yes", give details.) |

Additional Proposed Insured

l. Driver's license number: | _____ State: |

m. Have you had a charge or conviction of DWI/DUI or reckless driving in the last five (5) years? ☐ Yes ☐ No
(If "yes", give details.) |

n. Do you have any other moving violations in the last five (5) years? ☐ Yes ☐ No
(If "yes", give details.) |

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AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION

I hereby authorize any physician, medical practitioner, hospital, clinic or other medical related facility, insurance company, insurance support organization, business partner, pharmacy, pharmacy benefit managers, government agency, group policy holder, employer, benefit plan administrator, the Medical Information Bureau, the Department of Motor Vehicle Registration, and paramedical facility to provide to AMERICAN NATIONAL INSURANCE COMPANY, or to any agent, attorney, consumer reporting agency or independent administrator, including medical record retrieval services or pharmaceutical services, acting on AMERICAN NATIONAL INSURANCE COMPANY'S or its reinsurers' behalf, information concerning advice, care or treatment sought by or provided to me and/or any other applicant for coverage, including information relating to medical history, medical conditions, treatment, hospitalizations or confinements, ailments, and/or drug, alcohol or tobacco usage of the applicant(s). It is understood that American National underwriters, claim examiners, reinsurers, attorneys, or the medical director may disclose such health information to the aforementioned parties for purposes of underwriting, compliance, record clarification or explanation, or in response to litigation, summons, or subpoenas. I understand that after this information is disclosed, the recipient may redisclose it resulting in loss of protection by federal regulations.

I understand that:
(1) such information will be used by AMERICAN NATIONAL INSURANCE COMPANY for underwriting and insurability determinations;
(2) I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain life insurance coverage;
(3) a picture copy or photocopy of this authorization shall be as valid as the original; and
(4) any authorized representative of the proposed insured is entitled to receive a copy of this authorization upon request. This authorization is valid from the date signed for a duration of 24 months. I understand I may revoke the authorization at any time, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the Life Underwriting Department of AMERICAN NATIONAL INSURANCE COMPANY, P.O. Box 1720, Galveston, Texas 77553. *I may inspect or copy any information used or disclosed under this authorization, if signed.*

APPLICATION DECLARATIONS AND AGREEMENTS

Each of the undersigned declare for themselves, and all other interested parties, that all of the answers in all pages of this application and any supplements to it are full, complete and true to the best of their knowledge and belief. They also agree that: (1) these answers as written: (i) were given to induce the company to issue a policy; and (ii) shall form the basis for and become a part of any policy issued on this application; (2) except as otherwise provided in the conditional receipt with the same serial number as this application, no policy will be effective until it is: (i) issued; (ii) delivered to the applicant; and (iii) the full first premium paid, all during the lifetime and good health of the insured(s); (3) the company may issue a policy different from that specified in this application by listing the difference(s) on the policy data page, and acceptance of such different policy will be a ratification of the changes except that no change in: (i) amount of insurance; (ii) classification; (iii) plan of insurance; or (iv) benefits, will be effective unless agreed to by the applicant in writing; (4) the company is not bound by any statements made by anyone or any other facts known to anyone concerning any proposed insured(s) if not in writing in this application or any supplement, amendment, or modification to it which has been approved by the Company; and (5) only the president or a vice president or secretary of the company has the authority to waive any of the company rights or requirements or to waive or alter any of the provisions of: (i) this application and any supplement, amendment or modification to this application which has been approved by the Company; or (ii) any policy issued on this application including any supplement, amendment or modification to this application which has been approved by the Company.

FRAUD STATEMENT

Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and may subject such person to criminal and civil penalties.

FCRA / MIB ACKNOWLEDGEMENT

I have received the notification about the Federal Fair Credit Reporting Act and the Medical Information Bureau.

APPLICATION SIGNATURES

If Conditional Receipt to be attached, I hereby certify that I have read and received the conditional receipt, and agree to its terms. I understand that the company will not permit acceptance of my deposit or detachment of the conditional receipt unless this statement is true (if one given).

For Indexed Universal Life:
I understand that I am applying for an indexed universal life policy and that while the value of the policy may be affected by an external index, the policy does not directly participate in any stock or equity investment.

For Variable Universal Life:
I understand that I am applying for a Variable Universal Life Policy. The accumulation value may increase or decrease depending on investment returns and the death benefit may be variable or fixed depending on the death benefit option selected.

Date: Month/Day/Year: 2-24-14 | Signed at: City: North Augusta | State: S.C. | Country: USA

Witnessed by: Signature of licensed agent
X Leonard New

Print agent's name
Leonard New

Agent's state license number
203973

Agent's company personal code
DS829

Signature of primary proposed insured (Or guardian, if proposed insured is under age 16)
X Caroline C Shelnutt

Signature of additional person(s) proposed for insurance
X

Signature of additional person(s) proposed for insurance
X

Signature of owner if other than proposed insured
X

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AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION

Issued by American National Insurance Company
One Moody Plaza, Galveston, TX 77550-7999

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I hereby authorize any: physician, medical practitioner, hospital, clinic or other medical related facility, insurance company, insurance support organization, business partner, pharmacy, government agency, group policy holder, employer, benefit plan administrator, the Medical Information Bureau, the Department of Motor Vehicle Registration, and paramedical facility to provide to AMERICAN NATIONAL INSURANCE COMPANY, or to any agent, attorney, consumer reporting agency or independent administrator, including medical record retrieval services or pharmaceutical services, acting on AMERICAN NATIONAL INSURANCE COMPANY'S or its reinsurers' behalf, information concerning advice, care or treatment sought by or provided to me and/or any other applicant for coverage, including information relating to medical history, medical conditions, treatment, hospitalizations or confinements, ailments, and/or drug, alcohol or tobacco usage of the applicant(s). It is understood that American National underwriters, claim examiners, reinsurers, attorneys, or the medical director may disclose such health information to the aforementioned parties for purposes of underwriting, compliance, record clarification or explanation, or in response to litigation, summons, or subpoenas. I understand that after this information is disclosed, the recipient may redisclose it resulting in loss of protection by federal regulations.

I understand that:

(1) such information will be used by AMERICAN NATIONAL INSURANCE COMPANY for underwriting and insurability determinations;
(2) I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain life insurance coverage;
(3) a picture copy or photocopy of this authorization shall be as valid as the original; and
(4) any authorized representative of the proposed insured is entitled to receive a copy of this authorization upon request.

This authorization is valid from the date signed for a duration of 24 months. I understand I may revoke the authorization at any time, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the Life Underwriting Department of AMERICAN NATIONAL INSURANCE COMPANY, P.O. Box 1720, Galveston, Texas 77553. *I may inspect or copy any information used or disclosed under this authorization, if signed.*

2-24-14
Date

Caroline C. Sherlock
Proposed Insured (Please print)

Caroline C. Sherlock
Signature of Proposed Insured (or parent if Proposed Insured is under age 16)

PII 77
Birthdate

Additional Proposed Insured (Please print)

Signature of Additional Person Proposed for Insurance

Birthdate

Personal Representative designated by signature above is hereby authorized to execute this instrument based on: power of attorney, guardian-in-fact, guardian, payee representative, other _____ (Circle one)

Form 9332

AMERICAN NATIONAL INSURANCE COMPANY